DOCUMENT RESUME

ED 218 274 SP 020 449

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TITLE State Policy Support for School Health Education: A Review and Analysis.
INSTITUTION Education Commission of the States, Denver, Colo. Education Improvement Center.
SPONS AGENCY American Council of Life Insurance, Washington, D.C.; Health Insurance Association of America, Washington, D.C.
REPORT NO ECS-R-182-1
PUB DATE Jun 82
NOTE 50p.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Educational Policy; Elementary Secondary Education; *Government Role; *Health Education; State Boards of Education; *State Legislation; *State School District Relationship; *State Standards; Teacher Education

ABSTRACT

This report presents, discusses, and analyzes major findings of a 1981 survey on school health education conducted by the Education Commission of the States (ECS). The purpose of this study is to document state level support for activities in school health education. The survey focuses on the state education agency's role in the development of health education programs in local school districts. Findings are presented in the categories of: (1) roles of state boards of education in formulating and supporting implementation of state educational policy; (2) education codes and support from state legislatures; (3) state facilitation in program development; (4) roles of local school districts; and (5) state leadership groups. It is concluded that there is a high level of interest in school health education in many states, although it is noted that program support and resources committed to such programs vary. An appendix presents charts displaying data, from each state, on sources of support for school health education, health education as a high school graduation requirement, professional preparation for secondary school health teachers, health education staff in state education agencies, state health education guides, and state level leadership groups. The ECS state school health education survey questions are also appended. (JD)

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# State Policy Support for School Health Education:

## A Review and Analysis

Report No. 182-1

by Mary Noak
State School Health Education Project

U.S. DEPARTMENT OF EDUCATION
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Denver, Colorado

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June 1982

SP 020 449

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This publication was made possible by a grant from the American Council of Life Insurance and the Health Insurance Association of America. Points of view or opinions expressed herein do not necessarily represent the policies or positions of these groups.

# Acknowledgments

The author would like to thank the following individuals for providing assistance in the development and refinement of this publication.

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National Association of State Boards of Education

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National Center for Health Education

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# Preface

Henry David Thoreau once wrote: "It is not enough to be busy . . . . The question is: What are we busy about?"

This quotation seems to describe the essence of the current struggle in education today as educators and policymakers seek to redefine their goals and clarify roles and responsibilities.

Everyone is committed to the ideal of quality education, but no one is quite sure how to achieve it. One thing that we do know is that *school systems cannot teach everything.* Educators must examine and carefully select those parts of the curriculum that are most meaningful and relevant given the demands of living in today's world, i.e., they must emphasize the knowledge and skill areas that will enable children to function competently in the adult world.

There is a great deal of discussion and debate about what those critical knowledge and skill areas are. A number of studies have identified *knowledge and skills in health* as critical to adult functioning. If we review a typical day in our lives we will become aware of many health-related decisions and opportunities: what we eat – whether we wear seatbelts – how we deal with the stresses of our jobs – how we protect our children from disease . . the list is endless. It is clear that health knowledge and skills are an integral part of our lives. They are used daily in our roles as citizens and parents. Thus, health education is truly one of the "basics" of a quality education.

This publication documents the support that health education has received from state education policymakers. It is clear that many legislators, state board of education members and chief state school officers recognize its importance. They have emphasized its centrality in education in a variety of ways and have committed resources to the development and improvement of health

education programs in local school districts. The continuing support of these policymakers will be critical to the maintenance of the many outstanding programs that now exist and to the expansion of health education in the future.

# Executive Summary

This report presents, discusses and analyzes the major findings of the 1981 school health education survey conducted by the Education Commission of the States (ECS). The purpose of this study was to document state level support for and activities in school health education. The focus of the survey was the state education agency's role in the development of health education programs in local school districts. In compiling this information much was learned about the existing policy framework for school health education established by legislatures and state boards of education.

The major findings of the ECS school health education survey are as follows:

1. Education codes in 43 states address health education in some fashion. Thirty-seven states require health education or specific aspects of health instruction, e.g., information on the effects of drugs and alcohol on health, as a part of the public school curriculum.

2. Legislatures in seven states have reaffirmed the importance of health education in the education system by updating and expanding education codes pertaining to health instruction.

3. State lawmakers have demonstrated their support for school health education in ways other than education codes. The state survey revealed that legislative resolutions and memorials had been used in a few cases.

4. Thirty-seven state boards of education and the District of Columbia school board have addressed school health education in a variety of ways including policy or position statements, resolutions, guidelines, administrative regulations or bylaws.

5. State boards and legislatures have also expressed support for health education in other areas of education policy, such as mandatory topic areas in health, successful completion of a health course as a requirement for high school graduation and

professional preparation of health teachers. Twenty-four states require a definite amount of health instruction prior to graduation and 41 states now offer a health certification or endorsement for health teachers at the secondary level.

6. Forty-seven state education agencies and the District of Columbia employ a person who has primary responsibility for comprehensive health education. In addition, many state education agencies employ staff with training and expertise in particular aspects of health education.

7. Curriculum or planning guides for health education have been published in 34 states and the District of Columbia.

8. Although state education agencies may provide leadership, guidance and technical assistance in health education, local school districts make the final decisions regarding specific contents, instructional materials, teaching methods and teachers.

9. State school health or health education groups exist in 39 states.

The ECS school health education survey results indicate a great deal of interest in school health education and provide evidence of support from legislatures, state boards of education and state education agencies, as well as the private and voluntary sectors. Data gathered reveal a diversity of structures and processes related to school health education and the commitment of substantial resources to program planning, development and implementation.

Like most surveys, the ECS state school health education survey generated as many questions as it answered. A list of other possible research areas is provided for the reader.

# Introduction

In the winter of 1980-81, the Education Commission of the States (ECS) conducted a nationwide survey of state departments of education to document their activities in school health education. (For a definition of school health education, please refer to the Definitions section that follows.) Through this survey, ECS hoped to determine the level of state interest in and support for health instruction in the elementary and secondary schools. These data were to be incorporated into a publication on school health education that was being developed for state education policymakers.

Preliminary results of the survey were summarized in *Recommendations for School Health Education: A Handbook for State Policymakers*, which was published by ECS in the spring of 1981. However, to date, no report has discussed and analyzed the information obtained from the state survey.

The major purposes of this publication are to present, discuss and analyze the major findings of the ECS survey.

## Survey Process

To obtain the desired information, ECS health education staff contacted all state departments of education by telephone and interviewed personnel with primary responsibility for health education. These individuals were asked a variety of questions about their programs, including the extent of support from the state board of education and legislature, the level of staffing for health education and the role of the state education agency in facilitating program development. (For a full list and description of these questions, see Appendix 1.)

Most questions had a specific focus; however, health education specialists were encouraged to provide additional information on their program plans, problems and priorities. The information collected was organized into a state profile format, then sent back to the states for review and verification. Finally, ECS staff

modified the draft profiles based upon written corrections submitted by the specialists.

## Scope and Limitations

The following points should be borne in mind by those reviewing and studying this analysis and discussion.

1. This survey was undertaken to document the level of interest in and support for school health education nationally by examining the programs and activities of each state education agency. It is acknowledged that other state agencies, e.g., the state health department, may have involvement in health instruction in the schools, but the primary responsibility for classroom health education rests with the state education agency. The time and resource constraints of this project did not allow exploration of the role of other state agencies in school health education.
2. The survey was undertaken to document the current status of school health education. Data were collected for the purpose of describing state activities and programs, not evaluating them.
3. The program information collected was that *reported* by state education agency personnel. The accuracy of the data is, therefore, related to the specialist's familiarity with and knowledge of such things as state statutes, state board actions and state level advocacy activities.
4. The survey documented state level activities and programs at a particular point in time. Some change undoubtedly has occurred since the survey was conducted.
5. No attempt was made to determine the impact of state programs on local education agencies. Therefore, one must be cautious in making inferences about the quality of local programs from the existence of state level programs and activities. Although the state education agency can and does play a vital role in the quality of education offered at the local level, a number of variables affect the implementation of health education programs. These include the extent of administrative support and follow-through on policy and the extent of resources and coordination at both the state and local levels.

Two other variables play a very important part in local program implementation and thus deserve special attention. One is the effectiveness of the health education specialist employed by the

state education agency; the other is the nature of state/local relations.

State specialists often play a critical role in promoting health education as well as in assisting local districts in program planning and development. Thus, the professional preparation, leadership skills and commitment of these individuals often can influence the quality of local health education programs.

Another variable affecting local program implementation is the nature of state/local relations. Although the state education agency may have a commitment to health education as well as resources to devote to local program assistance, the perceptions and attitudes held in local districts about the state can affect the delivery of technical assistance. In some states, the state agency is viewed primarily as a regulatory body, and a somewhat adversarial relationship may exist between state personnel and personnel in local school systems. In these instances, it is unlikely that local education agencies will seek program assistance from the state. In states where a more cooperative relationship exists, local districts call upon the state agency for guidance and help in program development.

## Overview of Results

The ECS school health education survey results indicate a great deal of interest in school health education and provide evidence of support from legislatures, state boards of education and state education agencies, as well as the private and voluntary sectors. Data gathered reveal a diversity of structures and processes related to school health education and the commitment of substantial resources to program planning, development and implementation.

The nature and characteristics of each state's health education programs and activities reflect its unique economic, political and social environment. The survey data highlighted here present, in brief summary, each state's policy and program approach, which other states may wish to consider in designing their own programs and activities.

# Definitions

The following terms are used throughout the report and are defined here for the reader.

**Health**

A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1] A quality of life involving dynamic interaction and interdependence among the individual's physical well-being, his mental and emotional reactions, and the social complex in which he exists.[2]

**Health Education**

A process with intellectual, psychological, and social dimensions relating to activities that increase the abilities of people to make informed decisions affecting their personal, family, and community well-being.[3]

**School Health Education**

One component of a comprehensive school health program, it is a unified program of learning experiences:

- Planned by both school and community;
- With scope, sequence, progression and continuity;
- For grades kindergarten through 12;
- Taught by teachers trained and prepared in health education;
- Designed to develop critical thinking and individual responsibility for one's health;
- Structured to incorporate current and emerging health problems;
- Focused on the dynamic relationship between physical, mental, emotional and social well-being;
- Strengthened by integrating available community resources into classroom teaching.[4]

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[1] World Health Organization, 1967.

[2] *Health Education: A Conceptual Approach to Curriculum Design. School Health Education Study* (Washington, D.C.: 3M Education Press, 1967), p. 10.

[3] "Report of the 1972-1973 Joint Committee on Health Education Terminology," by representatives of the American Academy of Pediatrics; American Association of Health, Physical Education and Recreation; American College Health Association; American School Health Association; Public Health Education Section, American Public Health Association; School Health Section, American Public Health Association; Society for Public Health Education. *Health Education Monographs* (No. 33, 1973), pp. 65-66.

[4] Adapted from Northern California Chapter of the American Academy of Pediatrics paper cited in *Physician's Guide to the School Health Curriculum Process* (American Medical Association, 1980).

**Comprehensive School Health Education**

A program of learning experiences in health that includes, but is not limited to content in the following recommended areas:

- Personal health
- Mental and emotional health
- Prevention and control of disease
- Nutrition
- Substance use and abuse
- Accident prevention and safety
- Community health
- Consumer health
- Environmental health
- Family life education[5]

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[5] *Recommendations for School Health Education: A Handbook for State Policymakers.* (Denver, Colorado: Education Commission of the States, 1981) p. 8.

# Discussion and Analysis of State Survey Results

In the following pages, the major findings of the ECS school health education survey will be summarized, discussed and analyzed. For easy reference, selected state data have been organized and displayed in charts beginning on page 19.

## Support From the Legislature

Education codes[6] in 43 states address health education in some fashion. Thirty-seven states require health education or specific aspects of health instruction, e.g., information on the effects of drugs and alcohol on health, as a part of the public school curriculum. Six other states strongly recommend and support health education. (See Chart 1.) In many of these states, health instruction has not been defined either in scope or in terms of the amount of time that it should be assigned in the curriculum. For example, Kansas Education Code 72-1101 requires subjects in elementary school to include "health and hygiene." In Hawaii, the education code (296-11) states:

> . . . Under policies established by the board of education, the superintendent of education shall administer programs of education and public instruction throughout the state, including education at the pre-school, primary, and secondary school levels, health education and instruction, and such other programs as may be established by law.

It must be noted that many of these education codes were written years ago when infectious diseases caused most death and disability. At that time prevention consisted mainly of public health measures to improve living conditions (housing, sanitation, diet) that would reduce the incidence of these diseases. The role and responsibility of the individual in personal health care was very different from what it is today. Thus, the language in older education codes reflects a very different meaning and context for health education. For example, some codes refer to instruction in

[6] Laws governing education are called by a variety of names. "Education code" is used here in a generic sense.

"physiology and hygiene," which was probably the essence of health education years ago when communicable diseases were the most common health problems.

Many professionals and lay citizens tend to dismiss support of health instruction in education codes because of the outdated language and limited program scope implied. They feel that such obsolescence does nothing to enlighten people about health education nor to support their programs. While these laws do perpetuate a very narrow view of health education, they also suggest that even years ago the designers of the American education system recognized the importance of educating students about health. They emphasized its centrality in basic education by requiring or recommending it as a part of elementary and secondary school curricula.

As policymakers review and modify education codes to meet changing times and needs, a growing number are reiterating their support for health education. Legislatures in seven states (California, Colorado, Florida, Illinois, New York, North Carolina and Vermont) have reexamined health instruction as a part of the curriculum and reaffirmed its importance in the education system. For example, California Education Code, sec. 1, ch. 5.5, sec. 51881 of 1977 states:

> . . . The legislature finds and declares that an adequate health education program in the public schools is essential to continued progress and improvement in the quality of public health in this state, and the Legislature further believes that comprehensive health education, taught by properly trained persons, is effective in the prevention of disease and disability.

The state general assembly in Colorado has also recognized the importance of health education and in 1975 declared:

> Health and survival education is an essential element of public education in the state of Colorado. The school system is the most logical vehicle for conveying to children and parents significant health information and developing an awareness of the value of good health to the individual and to the community. It is further declared that many of the serious health problems in Colorado are directly attributable to the insufficient health knowledge and motivation of the school-age population and the general public. Therefore, it is necessary that more effort and money be made available for health and survival education as a positive approach for improved health in Colorado. . . . (Colorado Health and Survival Education Act, 22-25-101 through 22-25-112.)

In these seven states, education codes have been updated and expanded to reflect the practice of health education as we know it today. In several of these states, the scope of a health education program is articulated and either required or recommended. For example, Florida Education Code, sec. 233.067(3) as amended in 1978 states:

> As used in this section, the term "comprehensive health education" shall include, but not be limited to, such concerns as mental and emotional health, venereal diseases and other communicable diseases, drug abuse (including alcohol and tobacco), environmental health, safety and emergency care, nutrition and food management, personal health and hygiene, dental health, hereditary diseases, developmental disabilities, growth and development, and consumer health and careers.

Illinois Education Code, ch. 122, sec. 862 and 863, enacted in 1971, describes the purpose and contents of a comprehensive health education program:

> . . . "Comprehensive Health Education Program": a systematic and extensive educational program designed to provide a variety of learning experiences based upon scientific knowledge of the human organism as it functions within its environment which will favorably influence the knowledge, attitudes, values and practices of Illinois school youth; and which will aid them in making wise personal decisions in matters of health.
>
> The program established hereunder shall include, but not be limited to, the following major educational areas as a basis for curricula in all elementary and secondary schools in this State: human ecology and health, human growth and development, prevention and control of disease, public and environmental disease, consumer health, safety education and disaster survival, mental health and illness, personal health habits, alcohol, drug use and abuse, tobacco, nutrition and dental health.

While inclusion of health education in state education codes is a positive indication of support, one cannot generalize about the significance of this for program development. Implementation of these codes differs from state to state depending upon a number of variables including the sanctions and incentives included in the legislation, the support and interest of the legislature and the state board of education, the extent of accountability of the state education agency to the state board and the role of the chief state school officer in establishing and implementing education policy and priorities.

Some of the updated education codes, however, are more explici

about the state education agency's role in facilitating health education program development. Thus, legislative support is accompanied by a commitment of resources and the establishment of structures and processes that will enable local districts to develop health education programs. For example, sec. 115-204.1 of the North Carolina Education Code (1978) establishes a 10-year phase-in period for the development of health education in grades K-9; places responsibility for development and administration with specific state and local structures; apprises local education agencies of eligibility criteria for funding; defines the role of the state department of public instruction; and establishes a state school health advisory committee and describes its charge and membership.

*Other Means of Legislative Support*

State lawmakers have demonstrated their support for school health education in ways other than education codes. The state survey revealed that legislative *resolutions* and *memorials* had been used in a few cases.

A *memorial* is a document presented to a legislative body, or to the executive, by one or more individuals, containing a petition or representation of facts.[7] A *resolution* is a formal expression of the opinion or will of an official body or a public assembly, adopted by vote.[8] A *joint resolution* is one adopted by both houses of the legislature.

For example, in 1973 the Arkansas senate passed a resolution encouraging local school districts to teach health education one semester in both junior and senior high school.

A 1969 New Mexico senate memorial requested the Legislative School Study Committee and the state department of education to undertake a study of comprehensive health education and make recommendations for its implementation and financing.

A joint resolution of the New Mexico legislature in 1971 directed the state board of education to establish a new and improved program of health education for all public school children.

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[7]*Black's Law Dictionary*, St. Paul, Minn.: West Publishing Co. 1968, p. 1136.

[8]*Ibid*, p. 1474.

## Support From the State Board

The state board of education is the primary policymaking body for the state school system within the statutory framework established by the legislature.[9] In many states the state board has been empowered by the legislature to take an active role in formulating and supporting the implementation of education policy; in some states, board policy has the full force and effect of law.

These bodies often determine curriculum requirements and issue guidelines, standards, rules and regulations for program development and implementation. Thus, state boards of education can affect the nature of education offered at the local level and can be a powerful force in strengthening health education programs in the states.

The state survey documented that 37 state boards and the District of Columbia School Board have addressed school health education in a variety of ways including policy or position statements, resolutions, guidelines, administrative regulations or bylaws. (See Chart 2.) For example, in Alabama the state board passed a resolution encouraging local school districts to implement comprehensive health education programs in all schools, K-12, using the curriculum guide developed by the department of education.

In Iowa the state board authorized the formation of a task force to study school health education and last year went on record as supporting the need for health instruction in the schools and recommending a particular program scope.

A Maryland state board bylaw requires that family life and human development programs be offered in local districts K-12. In 1970 the board issued standards and procedures for the development of these programs.

The Pennsylvania state board has identified 12 goals of quality education, including the following:

> To help every child acquire good health habits and an understanding of the conditions necessary for maintaining physical and emotional well being.

It is difficult to generalize about the significance of these actions

[9] With one exception: There is no state board of education in Wisconsin.

for program development since the type of support as well as the impetus for it must be considered in relation to a particular state education context. Policy statements are different from administrative regulations, but their impact on state and local health education programs can only be determined by examining the particular environment and circumstances in which they occur. However, it does appear that a series of supportive actions, e.g., a policy statement followed by guidelines, is more effective than single isolated expressions of support.

## Other Forms of Policy Support

State boards and legislatures have also expressed support for health education in other areas of education policy, such as mandatory topic areas in health, successful completion of a health course as a requirement for high school graduation, and professional preparation of health teachers.

There are certain mandated topic areas in health in most states. Instruction related to alcohol, tobacco and drugs and their effects on health is the most common requirement. In many states these topics are listed in the education codes; in others, the state board has defined these requirements.

Many states have determined that particular kinds of knowledge and skills are of critical importance to students about to assume their role in an adult world. For this reason, they have established certain curriculum requirements that must be met before a student may graduate from high school. As of the 1981-82 school year, 24 states required a definite amount of health instruction prior to graduation. (See Chart 3.) It should be noted that in some states the local school board may also establish graduation requirements. A growing number are recognizing the importance of health knowledge and skills and are requiring health education.

The quality of health instruction is often determined by the interest and professional preparation of teachers. Many states have taken measures to assure that classroom teachers are adequately prepared to impart health knowledge and skills to children. Forty-one states now offer a separate health certification or endorsement for health teachers at the secondary level. (See Chart 4.) A health certification means that a certain amount of health-related coursework has been completed, a factor that contributes to, but does not guarantee, high quality health instruction.

At the elementary level, classroom teachers typically have responsibility for health education as they do for other curriculum areas. Since requirements for teacher certification vary state to state, the preparation of these teachers to provide health instruction varies considerably.

## State Facilitation in Program Development

Forty-seven state education agencies and the District of Columbia employ a person who has primary responsibility for comprehensive health education. Although in a few states, health education has been assigned to general curriculum consultants, most states have an individual with a health or physical education background in this position. These professionals often have other responsibilities, however, and the time available for health education varies considerably, from 25 to 100 percent. In addition, many state education agencies employ staff with training and expertise in particular aspects of health education. The most common responsibilities of these health education staff are physical education, nutrition education, alcohol and drug education, and driver's education and safety. (For a listing of health education staff in state education agencies, see Chart 5.)

Comprehensive health education specialists perform a variety of tasks that can be described as statewide leadership and technical assistance to local districts in program planning, development and implementation. In addition, they generally serve as liaison to official and voluntary health and education groups.

While the above statements regarding specialists' responsibilities are true, they are not completely accurate for state specialists focus on and emphasize different activities, depending on their unique problems, needs and resources. For example, some states including Delaware, Michigan, Missouri and Oregon have established a priority in teacher preparation (both preservice and inservice) as a way of improving health education in the schools. The state specialist then spends a great deal of time working on teacher certification and competency issues and developing and facilitating inservice training programs. Other states may have needs and priorities in other areas such as curriculum development, activating state-level leadership groups, providing policy-relevant information to state education officials, serving as a clearinghouse and resource broker, or auditing local programs.

Curriculum or planning guides for health education have been

published in 34 states and the District of Columbia.[10] (See Chart 6.) These guides are for the purpose of assisting local districts in designing their health education curricula to meet legal as well as educational and professional standards. The contents of these guides have been described elsewhere (Kupsinel, 1978), but those now being developed or updated contain a greater emphasis on minimum competencies and learner outcomes than did previous ones. For example, at the time of this survey, Georgia was in the process of revising its health education curriculum guides. A major aspect of this revision was the incorporation of objectives and performance indicators designed to measure competency in health. In Louisiana, a competency-based curriculum guide was then being field tested in a number of local school districts in the state.

## Role of Local Districts

While the ECS survey focused on state-level school health education programs, staff wanted to clarify the part played by local districts. The following question was asked of state specialists: Did local districts have the freedom to develop health education programs to meet their own needs and resources? State education agency staff without exception responded positively and stressed that local districts play a significant role in program development. Most state education agencies recommend or suggest topics to be included in the health education curriculum and provide technical assistance in program development, but local school systems make the final decisions regarding specific contents, instructional materials, teaching methods and teachers. Thus, it is not uncommon to find greater (or less) interest in health education at the local level than exists at the state level.

## State Level Leadership Groups

State school health or health education groups exist in 39 states. (See Chart 7.) Some of these are interagency committees made up primarily of staff from state agencies, but many have broad-based representation, with members from the state departments of health and education; higher education institutions; parent, teacher and student organizations; local school boards and school administration; and voluntary health agencies. These groups often function in an advisory, coordinating and/or advocacy role.

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[10]This number does not include those under development at the time of the survey.

Because of the new emphasis on state roles and responsibilities, these groups will assume greater importance than ever before in the development and maintenance of health education programs in the school systems.

## Conclusion

In summary, there is a high level of interest in school health education in many states, although program support and resources committed to the program vary.

Like most surveys, the ECS state school health education survey generates as many questions as it answers. Exploration of the following areas would add to our information and thus yield a more precise description of the current status of health education in the school systems.

What is (are):

1. The exact dates (years) that state education codes were enacted?
2. The impetus for revising and updating education code sections concerning health education?
3. The amount of financial support provided for health education programs in state education agencies?
4. The exact dates (years) that state board actions took place and the impetus for such actions?
5. The amount of health-related coursework required for regular teacher certification?
6. The role of other official and voluntary state agencies in school health education?
7. The length of time health education specialists have been employed within the state education agency?
8. The professional preparation and training of health education specialists?
9. The particular emphases of the state education agencies in health education and the impact of those emphases on local program improvement?
10. The composition, activities and impact of state-level leadership groups?
11. The impact of state education agency activities on local health education programs (and vice versa)?

# Appendix 1: ECS State School Health Education Survey Questions

| | |
|---|---|
| **Legal Basis** | What state statutes and/or other legislative actions support the inclusion of health education in the curricula of elementary and secondary schools? |
| **Special Appropriations** | Has the legislature appropriated any specific monies to implement school health education programs? |
| **State Board of Education Policy or Position Statements** | Has the state board of education expressed its support for school health education in any policy or position statements? |
| **Other State Board Actions** | Has the state board taken any other actions that address school health education? |
| **Mandatory Topics and Grade Levels** | What specific health topics are required to be taught and at what grade levels? |
| **Time Requirements** | Are there any specific time requirements for health education in the curriculum? |
| **Health Education Graduation Requirements** | Is health education a requirement for graduation from high school? If so, how much is required? |
| **State Curriculum Guide** | Has the state education agency published a guide to help local districts in developing a health education curriculum? |
| **Local Autonomy in Curriculum Development** | Do local districts have freedom to develop curricula and programs to meet their own needs and resources? |
| **School Health Education Specialist** | Is there a person at the state department of education who has responsibility for assisting local districts in the planning and development of health education programs? If so, is he or she full-time and what are his or her other responsibilities (if any)? |

| | |
|---|---|
| **Role of the Specialist** | What are the most common responsibilities and tasks of the school health education specialist? |
| **Other Health-Related Staff** | What other types of health-related staff work in the state education agency? |
| **Certification to Teach Health** | Does the state require anything beyond teacher certification to teach health in the classroom? |
| **State-Level School Health or School Health Education Group** | Is there any statewide group(s) that has interest in school health or health education issues and provides leadership in this area? |

# Appendix 2: Charts

Chart 1
Legislative Support

| | Education Code Requires* | Education Code Recommends** | Other |
|---|---|---|---|
| Alabama | X | | |
| Alaska | | X | |
| Arizona | | | |
| Arkansas | X | | [1] |
| California | | X | |
| Colorado | | X | |
| Connecticut | X | | |
| Delaware | X | | |
| District of Columbia | | | |
| Florida | | X | |
| Georgia | X | | |
| Hawaii | X | | |
| Idaho | X | | |
| Illinois | | X | |
| Indiana | X | | |
| Iowa | X | | |
| Kansas | X | | |
| Kentucky | | | |
| Louisiana | X | | |
| Maine | X | | |
| Maryland | X | | |
| Massachusetts | X | | |
| Michigan | X | | |
| Minnesota | X | | |

[1] Senate Resolution

*Requires health education or specific aspects of health instruction.

**Strongly recommends and supports development and implementation of health education or specific aspects of health instruction.

| | Education Code Requires* | Education Code Recommends** | Other |
|---|---|---|---|
| Mississippi | X | | |
| Missouri | | | |
| Montana | | | |
| Nebraska | X | | |
| Nevada | X | | |
| New Hampshire | X | | |
| New Jersey | X | | |
| New Mexico | | | [2] |
| New York | X | | |
| North Carolina | X | | |
| North Dakota | X | | |
| Ohio | X | | |
| Oklahoma | X | | |
| Oregon | | | |
| Pennsylvania | X | | |
| Rhode Island | X | | |
| South Carolina | X | | |
| South Dakota | X | | |
| Tennessee | X | | |
| Texas | X | | |
| Utah | X | | |
| Vermont | | X | |
| Virginia | X | | |
| Washington | X | | |
| West Virginia | X | | |
| Wisconsin | X | | |
| Wyoming | | | |

[2] Senate Memorial and Joint Resolution

*Requires health education or specific aspects of health instruction.

**Strongly recommends and supports development and implementation of health education or specific aspects of health instruction.

## Chart 2
## State Board Support

| | Type of Support |
|---|---|
| Alabama | Adoption of resolution that encourages local program development |
| Alaska | |
| Arizona | Mandate that health be taught in the elementary schools |
| Arkansas | |
| California | Adoption of *Health Instruction Framework* |
| Colorado | Adoption of rules and regulations pursuant to education code; approval of certificate in health education |
| Connecticut | |
| Delaware | Adoption of state education objectives that include health |
| District of Columbia | Adoption of policy supporting instruction about human sexuality and reproduction; approval of curriculum guides and textbook list |
| Florida | |
| Georgia | Adoption of policy requiring one quarter of health for high school graduation; standards for public schools include health education |
| Hawaii | Adoption of Foundation Program Objectives that include health |
| Idaho | Standards for Elementary and Secondary Schools include health |
| Illinois | Adoption of policy statement and general guidelines for family life and sex education; adoption of resolution and recommendations relative to alcohol/drug education |
| Indiana | |
| Iowa | Authorization to establish state task force on health education; approval of philosophy and need for health education and scope of program |
| Kansas | Adoption of policy on sex education |
| Kentucky | Adoption of administrative regulation that requires local school boards to include health instruction in the curriculum |

| | Type of Support |
|---|---|
| Louisiana | |
| Maine | Adoption of guidelines for health, safety and physical education |
| Maryland | Adoption of board bylaw that requires family life and human development be offered K-12; adoption of standards and procedures for the development of these programs |
| Massachusetts | Adoption of objectives for education that include health |
| Michigan | Adoption of position paper on the Michigan Comprehensive School Health Program; performance objectives for essential skills include health; guidelines for comprehensive health education and sex education issued; comprehensive school health plan developed |
| Minnesota | Adoption of position paper on comprehensive school health education |
| Mississippi | |
| Missouri | Adoption of curriculum guide that contains position statement on the need for health education |
| Montana | Adoption of mandate for elementary health education plus 2 years at the secondary level |
| Nebraska | Implementation statement in board regulation |
| Nevada | Adoption of position paper on comprehensive school health education |
| New Hampshire | Adoption of policy statement on comprehensive health education program |
| New Jersey | Adoption of resolution that encourages local program development K-12; rules and regulations issued on family life education |
| New Mexico | Adoption of education standards that provide for health education as a part of the required curriculum in elementary, junior high/middle school, and senior high levels; position paper on comprehensive health education |
| New York | |
| North Carolina | Issuance of standards and regulations pursuant to education code |
| North Dakota | |

| | Type of Support |
|---|---|
| Ohio | Adoption of minimum standards including health for elementary, junior high and high schools |
| Oklahoma | Issuance of regulations to implement education codes |
| Oregon | Adoption of administrative rule mandating that health education be offered K-9 and that students take 1 year sometime during grades 9-12 |
| Pennsylvania | Adoption of state goals of quality education that include health; curriculum regulations on health and physical education; guidelines for sex education |
| Rhode Island | Regulations on school health programs include a brief discussion of health instruction |
| South Carolina | Adoption of defined minimum program that includes health education |
| South Dakota | Adoption of rules that require health in all elementary schools and health and physical education in middle and junior high school |
| Tennessee | |
| Texas | Adoption of rule that the inclusion of sex education is a local district decision; issuance of guidelines for the development of a sex education course |
| Utah | Adoption of resolutions, counsel to teaching training institutions regarding health education |
| Vermont | Adoption of guidelines to implement education code; consideration of proposed new regulations for the approval of public elementary and secondary schools that include a requirement that health education be offered and defines program scope |
| Virginia | Adoption of policy statement on health education; issuance of regulations on driver education, drug education and sex education |
| Washington | |
| West Virginia | Adoption of mandate for health as a separate course or in combination with health science K-8 and 1 credit at the senior high level |
| Wisconsin | No state board of education in Wisconsin |
| Wyoming | |

## Chart 3
## Health Education as a High School Graduation Requirement

| | |
|---|---|
| Alabama* | |
| Alaska | |
| Arizona | |
| Arkansas | 1 unit of health and physical education |
| California | |
| Colorado | |
| Connecticut | |
| Delaware | 1/2 unit of health (separate from physical education) |
| District of Columbia | |
| Florida | |
| Georgia | 1 quarter of health education |
| Hawaii | 1/2 credit of health education |
| Idaho | 1 semester of health in junior or senior high |
| Illinois | 1 semester of health education |
| Indiana | 1 unit required, but 4 credits of home economics may fulfill the health and safety requirement |
| Iowa | |
| Kansas | |
| Kentucky | 1/2 unit of health education |
| Louisiana | 30 hours of health instruction required during each of 2 years in high school |
| Maine | |
| Maryland | |
| Massachusetts | |
| Michigan | |
| Minnesota | 1/2 credit in health education |

*Effective 1982-1983 school year, one semester of health will be required during grades 10, 11 or 12.

| | |
|---|---|
| Mississippi | Effective 1981-82 school year, 16-week unit of health education required in grades 7-12 |
| Missouri | |
| Montana | 2 years of health and physical education required |
| Nebraska | |
| Nevada | 1/2 unit of health education |
| New Hampshire | |
| New Jersey | Must pass health, physical education and safety |
| New Mexico | |
| New York | 1/2 unit health education |
| North Carolina | 1 unit (includes physical education) |
| North Dakota | |
| Ohio | 1/2 unit of health (60 hours minimum) |
| Oklahoma | |
| Oregon | 1 year of health education during grades 9-12 |
| Pennsylvania | 1 course in senior high school |
| Rhode Island | |
| South Carolina | |
| South Dakota | |
| Tennessee | 1/2 unit of health education |
| Texas | 1 semester during grades 9-12 |
| Utah | 1 semester during grades 10, 11 or 12 |
| Vermont | |
| Virginia | 2 units in health and physical education — at least 40 percent of the instruction time for health and physical education shall be devoted to health. The classroom phase of driver education may be included in health. |
| Washington | |
| West Virginia | 1 credit |
| Wisconsin | |
| Wyoming | |

## Chart 4
## Professional Preparation for Secondary Health Teachers*

| | |
|---|---|
| Alabama | Separate health certification |
| Alaska | Regular teacher certification |
| Arizona | Regular teacher certification |
| Arkansas | Separate health certification |
| California | Separate health certification |
| Colorado | K-12 endorsement in health can be placed on teacher certificate upon completion of approved program |
| Connecticut | Separate health certification |
| Delaware | Separate health certification |
| District of Columbia | Dual health and physical education certification |
| Florida | Separate health certification, grades 7-12 |
| Georgia | Separate health and dual (health and physical education) certification |
| Hawaii | Separate health and dual (health and physical education) certification |
| Idaho | Separate health certification |
| Illinois | Separate health certification as well as minimum standards for teachers |
| Indiana | Separate health certification |
| Iowa | Separate health certification (if taught as a separate subject) |
| Kansas | Separate health and dual (health and physical education) certification |

*Because of the manner in which the question was asked, it is unclear in which states a separate certification is required rather than available. The difference between a separate health certification and a health endorsement is also unknown.

| | |
|---|---|
| Kentucky | Dual health and physical education certification |
| Louisiana | Separate health and dual (health and physical education) certification |
| Maine | Separate health and dual (health and physical education) certification |
| Maryland | Separate health certification |
| Massachusetts | Separate health certification, K-9 or 8-12 |
| Michigan | Separate health certification |
| Minnesota | Separate health certification |
| Mississippi | Dual health and physical education certification |
| Missouri | Separate health certification |
| Montana | Regular teacher certification |
| Nebraska | Separate health and dual (health and physical education) endorsement |
| Nevada | Separate health certification |
| New Hampshire | Separate health certification |
| New Jersey | Separate health and dual (health and physical education) certification |
| New Mexico | Health endorsement |
| New York | Separate health certification |
| North Carolina | Separate health certification |
| North Dakota | Separate health certification |
| Ohio | Separate health certification, K-12 and 7-12 |
| Oklahoma | Dual health and physical education certification |
| Oregon | Separate health certification |
| Pennsylvania | Separate health and dual (health and physical education) certification |
| Rhode Island | Separate health certification |
| South Carolina | Separate health certification |
| South Dakota | Dual health and physical education certification |

| | |
|---|---|
| Tennessee | Regular teacher certification |
| Texas | Separate health certification for secondary level; elementary certificate with an emphasis in health also available |
| Utah | Separate health certification |
| Vermont | Separate health certification |
| Virginia | Separate health and dual (health and physical education) certification. As of July 1982, the dual certification will be dropped. |
| Washington | Separate health certification |
| West Virginia | Separate health certification |
| Wisconsin | Separate health certification |
| Wyoming | Regular teacher certification |

## Chart 5
## Health Education Staff in State Education Agencies

| | Comprehensive Health Education Specialist | Other Health Education Staff |
|---|---|---|
| Alabama | X | 1 in physical education/ recreation; 1 in safety and driver's education |
| Alaska* | X | |
| Arizona | | |
| Arkansas | X | 1 in physical education; 3 in nutrition education |
| California | X | 1 in dental health; 1 in drug/alcohol education; 1 in genetic disorders; 1 in sexually transmitted diseases |
| Colorado | X | 1 in nutrition education; 1 in driver education and safety; 1 in youth traffic safety, bicycle and pedestrian safety |
| Connecticut | | |
| Delaware | X | 1 in physical education; 1 in nutrition education |
| District of Columbia | X | 1 in drug abuse prevention; 1 in nutrition education |
| Florida | X | 1 in physical education; 1 in health occupations (vocational education); 2 in nutrition education |
| Georgia | X | 1 in health and physical education; 1 in nutrition education; 1 in driver education and safety |

*In these states, health education is a part of the responsibilities of general curriculum and program development consultants.

| | Comprehensive Health Education Specialist | Other Health Education Staff |
|---|---|---|
| Hawaii | X | 1 in nutrition education; 2 in environmental education; 1 in physical education; 1 in student safety |
| Idaho | X | 1 in nutrition education; 2 in driver education and safety |
| Illinois | X | 2 in nutrition education |
| Indiana | | |
| Iowa | X | 2 in substance abuse prevention; 1 in nutrition education; 1 in safety education |
| Kansas | X | 1 in parenting education; 1 in nutrition education; 1 in driver's education |
| Kentucky | X | 1 in physical education; 2 in nutrition education; 1 in driver's education and safety |
| Louisiana | X | 1 in physical education; 6 in safety education; 2 in drug abuse prevention; 3 in nutrition education |
| Maine | X | 3 in substance abuse prevention; 3 in nutrition education; 1 in health careers (vocational education) |
| Maryland | X | 1 in physical education; 1 in safety; 1 in nutrition education |
| Massachusetts | X | 8 in nutrition education |
| Michigan | X | 2 in safety education; 1 in nutrition education; 1 in vocational education |

| | Comprehensive Health Education Specialist | Other Health Education Staff |
|---|---|---|
| Minnesota | X | 2 in nutrition education; 4 in drug education; 1 in safety and driver's education |
| Mississippi | X | 1 in health, physical education and recreation; 1 in safety education |
| Missouri | X | 1 in nutrition education |
| Montana | X | 1 in nutrition education; 1 in driver education/safety |
| Nebraska | X | 2 in nutrition education; 2 in safety and driver's education |
| Nevada | X | 1 in nutrition education |
| New Hampshire | X | 1 in nutrition education; 1 in health occupations (vocational education) |
| New Jersey* | X | Nutrition education staff |
| New Mexico | X | |
| New York | X | 1 in health education; 3 in drug education; 3 in nutrition education; 3 in safety education |
| North Carolina | X | 3 in health education; nutrition education staff; 1 in safety education |
| North Dakota | X | 1 in nutrition education; 1 in traffic safety |
| Ohio | X | |
| Oklahoma | X | 2 in health education; nutrition education staff; driver's education and safety staff |

*In these states, health education is a part of the responsibilities of general curriculum and program development consultants.

| | Comprehensive Health Education Specialist | Other Health Education Staff |
|---|---|---|
| Oregon | X | 1 in traffic safety; 1 in career education |
| Pennsylvania | X | 1 in physical education; 1 in nutrition education; 2 in safety education; 2 in alcohol and drug education |
| Rhode Island* | X | 1 in nutrition education |
| South Carolina | X | 2 in drug education; 1 in alcohol education; 1 in physical education; 1 in nutrition education; 1 in driver education/ traffic safety; 1 in environmental education |
| South Dakota* | X | |
| Tennessee | X | 3 in health, physical education and safety; 2 in nutrition education |
| Texas | X | Nutrition education staff |
| Utah | X | 1 in health occupations (vocational education) |
| Vermont | X | Temporary elementary traffic safety consultant |
| Virginia | X | 3 supervisors of health and physical education, emphasis differs; 3 supervisors of driver education |
| Washington | X | 1 in nutrition education; 1 in driver's education |
| West Virginia | X | 1 in traffic safety |

*In these states, health education is a part of the responsibilities of general curriculum and program development consultants.

| | Comprehensive Health Education Specialist | Other Health Education Staff |
|---|---|---|
| Wisconsin | X | 1 in alcohol and drug education; 1 in human growth and development; 1 in nutrition education |
| Wyoming | X | 1 in traffic safety; 1 in driver's education; 1 in nutrition education |

## Chart 6
## State Health Education Guides

| | Title | Scope | Year Published |
|---|---|---|---|
| Alabama | Health Education Curriculum Guide for Alabama | K-12 | 1977 |
| Alaska | A Framework for Health Education in Alaska Schools | K-12 | 1976 |
| Arizona | What Every Child Should Know . . . Health Course of Study for Textbook Selection | K-8 | 1973 |
| Arkansas | | | |
| California | Health Instruction Framework for California Public Schools | [1] | 1978 |
| Colorado | Colorado School Health Guidelines (a planning and resource guide) | | 1977 |
| Connecticut | | | |
| Delaware | Currently being revised | | |
| District of Columbia | Health and Family Life Education | Pre K-6 | 1978 |
| | Secondary Health and Physical Education Guide | 7-8, 10 | 1975 |
| Florida | Ideas in Health Education (a source book to aid in the development of creative approaches to health education) | | 1972 |
| Georgia | Building a Better You | K-6 | 1975 |
| | Building a Better You (revision in process for 7-12) | 7-12 | 1976 |
| Hawaii | Health Education Instructional Guide | K-6 | 1973 |
| | Health Education Instructional Guide | 7-12 | 1977 |

[1] Preschool through young adult years

| | Title | Scope | Year Published |
|---|---|---|---|
| Idaho | Getting to Know Me | K-3, 4-6 | 1978 |
| | The Way I Am | 7-12 | 1979 |
| Illinois | | | |
| Indiana | | | |
| Iowa | Health education curriculum tool being developed to help in program assessment and design | | |
| Kansas | Health Education Guidelines for Curriculum Development | K-12 | 1973 |
| Kentucky | | | |
| Louisiana | Competency based curriculum guide now being field tested | | |
| Maine | | | |
| Maryland | Comprehensive Health Education Curriculum Guide | K-12 | |
| Massachusetts | Out of print | | |
| Michigan | State has minimum performance objectives in health education | | |
| Minnesota | Resource Unit on Health and Safety Education | K-12 | 1977 |
| Mississippi | | | 1968 |
| Missouri | Comprehensive School Health Education Instruction Guide | K-12 | 1976 |
| Montana | Montana School Health Curriculum Guide out of print; due to be revised | | 1977 |
| Nebraska | Guidelines for Comprehensive Health Education | K-12 | 1978 |

| | Title | Scope | Year Published |
|---|---|---|---|
| Nevada | Comprehensive Health Education for Elementary Schools | K-6 | 1974 |
| | Comprehensive Health Education for Junior High Schools | | 1976 |
| New Hampshire | Will be available in the fall of 1981 | | |
| New Jersey | Guidelines for Health Education | K-12 | 1975 |
| New Mexico | | | |
| New York | Under revision | | |
| North Carolina | A Framework for Health Education | K-12 | 1975 |
| | Course of Study in Health Education | K-12 | 1978 |
| | Competency Goals and Performance Indicators | | 1979 |
| North Dakota | Health Instruction Guide for North Dakota Schools | 1-12 | 1965 |
| Ohio | Guidelines for Improving Health Education | K-12 | 1980 |
| Oklahoma | Use curriculum guides from other states as resource materials along with recommendations from national organizations in curriculum development | | |
| Oregon | Planning Health Education in Oregon Schools — Administration | K-12 | 1978 |
| Pennsylvania | Conceptual Guidelines on School Health Programs in Pennsylvania | K-12 | 1980 |
| Rhode Island | Out of print | | |
| South Carolina | Comprehensive Health Education Guide (4 guides) | K-2<br>3-5<br>6-8<br>9-12 | 1975 |

| | Title | Scope | Year Published |
|---|---|---|---|
| South Dakota | Draft being field tested | | |
| Tennessee | Currently revising and field testing guide | | |
| Texas | Framework for Health Education | K-12 | 1981 |
| Utah | A Course of Study for Elementary Health Education in Utah Schools | | 1979 |
| | Junior and senior high guides currently being revised | | |
| Vermont | Utilize other state guides as resources | | |
| Virginia | Health Education | K-7 | 1978 |
| | Health Education | 7-12 | 1978 |
| Washington | Framework for Student Learning Objectives | K-12 | 1980 |
| West Virginia | | | |
| Wisconsin | Health Education, a Planning Resource for Wisconsin Schools | K-12 | 1977 |
| Wyoming | | | |

## Chart 7
## State Level Leadership Groups

| | |
|---|---|
| Alabama | Health Education Advisory Committee (to the state board of education) |
| Alaska | State Health Coordinating Council; Alaska Health Education Consortium |
| Arizona | |
| Arkansas | Governor's Council on School Health Services and Education |
| California | California School Health Alliance; California School Health Association |
| Colorado | Colorado School Health Council |
| Connecticut | Connecticut School Health Advisory Council |
| Delaware | School Health Advisory Committee; State Medical Society School Health Committee |
| District of Columbia | |
| Florida | School Health Medical Advisory Committee of the Florida Medical Association |
| Georgia | Interagency Committee on School Health; State Medical Association Committee on Health Education |
| Hawaii | Interagency School Health Planning Group; Governor's Advisory Committee on School Health |
| Idaho | |
| Illinois | State Health Education Advisory Committee; State Sex Education Advisory Board |
| Indiana | Indiana Consortium of University Representatives; School Nurse Consortium; Governor's Council on Physical Fitness and Sports Medicine; Indiana Health Educators Association; Indiana Association for Health, Physical Education and Recreation |
| Iowa | School Health Education Advisory Committee (approved by the state board but not yet funded) |
| Kansas | Kansas Association for School Health |

| | |
|---|---|
| Kentucky | Kentucky School Health Association; Kentucky Assocation for Health, Physical Education and Recreation; Kentucky School Nurses Association |
| Louisiana | |
| Maine | School Health Board of Directors |
| Maryland | Maryland School Health Council |
| Massachusetts | School Health Task Force of the Massachusetts Health Council |
| Michigan | Health Education Referrent Group (advisory to the state department of education); Michigan School Health Association; Michigan Alliance for Health, Physical Education, Recreation and Dance |
| Minnesota | |
| Mississippi | State Health Coordinating Council |
| Missouri | Comprehensive Health Education Coalition; Governor's Commission on Children and Youth |
| Montana | Joint Staff Committee (state department of public instruction and state department of health) |
| Nebraska | |
| Nevada | |
| New Hampshire | Comprehensive School Health Program Committee |
| New Jersey | School Health Education Council; New Jersey Association of Health, Safety, Physical Education, Recreation and Dance |
| New Mexico | New Mexico School Health Association |
| New York | |
| North Carolina | State School Health Advisory Committee |
| North Dakota | |
| Ohio | State Planning Committee for Health Education; Ohio Association for Health, Physical Education, Recreation and Dance |
| Oklahoma | School Health Education Task Force; Oklahoma Health Education Advisory Council |

| | |
|---|---|
| Oregon | Health Education Advisory Committee (to the superintendent of public instruction) |
| Pennsylvania | School Health Education Task Force; Pennsylvania Association for Health and Physical Education |
| Rhode Island | |
| South Carolina | Joint State Health/Education Committee |
| South Dakota | |
| Tennessee | State Health Planning Council |
| Texas | Comprehensive School Health Advisory Committee (to the state board of education) |
| Utah | School Health Advisory Committee (to the state board of education); Joint Health and Education Committee; State Course of Study Committee for Health and Physical Education |
| Vermont | State Advisory Council on Comprehensive Health Education (to the state department of education) |
| Virginia | Virginia State Health Advisory Council |
| Washington | Health Education Alliance |
| West Virginia | School Health Education Council |
| Wisconsin | State School Health Council; State Medical Society School Health Committee; State Superintendent's Advisory Council on Health Problems Education; Wisconsin Association for Health, Physical Education and Recreation |
| Wyoming | |

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